FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041046

Facility Name: PROVENA COR MARIAE CENTER

Address: 3330 MARIA LINDEN DR (Number) ROCKFORD (City) 61114 (Zip Code)

County: WINNEBAGO

Telephone Number: (815) 877-7416 **Fax #** (815) 877-4299

IDPA ID Number: 371127787013

Date of Initial License for Current Owners: 06/01/95

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) STEVEN N. LAVENDA, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 5/31/01

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	63	Skilled (SNF)	63	23,058	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	55	Sheltered Care (SC)	61	21,359	5
6		ICF/DD 16 or Less			6
7	118	TOTALS	124	44,417	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	419	6,489	3,734	10,642	8
9	SNF/PED					9
10	ICF	2,966	8,492		11,458	10
11	ICF/DD					11
12	SC		19,088		19,088	12
13	DD 16 OR LESS					13
14	TOTALS	3,385	34,069	3,734	41,188	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.73%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 6/5/1995

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 6/5/1995 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 41 and days of care provided 3734

Medicare Intermediary ADMINASTAR FEDERAL, INC.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	325,836	52,430	9,519	387,785		387,785	(58,439)	329,346			1
2	Food Purchase		256,669		256,669		256,669	(38,705)	217,964			2
3	Housekeeping	120,647	28,445		149,092		149,092	(20,880)	128,212			3
4	Laundry	54,092	8,235		62,327		62,327		62,327			4
5	Heat and Other Utilities			242,470	242,470		242,470	(45,945)	196,525			5
6	Maintenance	109,732	63,680	85,336	258,748		258,748	(67,251)	191,497			6
7	Other (specify):*											7
8	**TOTAL General Services**	610,307	409,459	337,325	1,357,091		1,357,091	(231,220)	1,125,871			8
	B. Health Care and Programs											
9	Medical Director			12,600	12,600		12,600		12,600			9
10	Nursing and Medical Records	1,264,953	87,017	16,419	1,368,389		1,368,389	12,545	1,380,934			10
10a	Therapy	42,942			42,942		42,942		42,942			10a
11	Activities	142,798	13,473	338	156,609		156,609	(53,333)	103,276			11
12	Social Services	110,166	5,667	9,333	125,166		125,166	5,720	130,886			12
13	Nurse Aide Training											13
14	Program Transportation			160	160		160		160			14
15	Other (specify):*							4,835	4,835			15
16	**TOTAL Health Care and Programs**	1,560,859	106,157	38,850	1,705,866		1,705,866	(30,233)	1,675,633			16
	C. General Administration											
17	Administrative	72,989		536,394	609,383		609,383	(480,452)	128,931			17
18	Directors Fees											18
19	Professional Services			70,056	70,056		70,056	15,092	85,148			19
20	Dues, Fees, Subscriptions & Promotions			61,129	61,129		61,129	(48,040)	13,089			20
21	Clerical & General Office Expenses	129,596	31,797	71,143	232,536		232,536	48,212	280,748			21
22	Employee Benefits & Payroll Taxes			435,803	435,803		435,803	(34,608)	401,195			22
23	Inservice Training & Education							18,330	18,330			23
24	Travel and Seminar			14,814	14,814		14,814	(8,540)	6,274			24
25	Other Admin. Staff Transportation			620	620		620	4,316	4,936			25
26	Insurance-Prop.Liab.Malpractice			21,455	21,455		21,455	(2,165)	19,290			26
27	Other (specify):*							39,917	39,917			27
28	**TOTAL General Administration**	202,585	31,797	1,211,414	1,445,796		1,445,796	(447,938)	997,858			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,373,751	547,413	1,587,589	4,508,753		4,508,753	(709,391)	3,799,362			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PROVENA COR MARIAE CENTER #0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			275,033	275,033		275,033	(65,606)	209,427			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							241,753	241,753			32
33	Real Estate Taxes			938	938		938	(938)				33
34	Rent-Facility & Grounds							11,484	11,484			34
35	Rent-Equipment & Vehicles			105	105		105		105			35
36	Other (specify):*											36
37	TOTAL Ownership			276,076	276,076		276,076	186,693	462,769			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		512,019	203,531	715,550		715,550		715,550			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,499	34,499		34,499		34,499			42
43	Other (specify):*	16,472	3,217	2,090	21,779		21,779	(21,779)				43
44	TOTAL Special Cost Centers	16,472	515,236	240,120	771,828		771,828	(21,779)	750,049			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,390,223	1,062,649	2,103,785	5,556,657		5,556,657	(544,477)	5,012,180			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(30)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,949	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(38,671)	21		24
25	Fund Raising, Advertising and Promotional	(50,030)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(540,463)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (619,245)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	74,768		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 74,768		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (544,477)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

PROVENA COR MARIAE CENTER

ID# 0041046

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	CABLE TELEVISION	$ (12,029)	05	1
2	EXECUTIVE BENEFITS	(4,979)	22	2
3	DEVELOPMENT SALARIES	(16,472)	43	3
4	DEVELOPMENT SUPPLIES	(3,217)	43	4
5	DEVELOPMENT OTHER	(2,090)	43	5
6	NON-ALLOWABLE SEMINAR	(14,814)	24	6
7	CAPITALIZED R&M	(7,122)	06	7
8	STIPENDS	(2,439)	21	8
9	PRIOR PERIOD LEGAL FEES	(1,495)	19	9
10	NON-ALLOWABLE REAL ESTATE TAX	(938)	33	10
11	NON-CARE ASSET DEPRECIATION	(75,555)	30	11
12	NON-ALLOWABLE DIETARY	(58,439)	01	12
13	NON-ALLOWABLE FOOD	(38,675)	02	13
14	NON-ALLOWABLE HOUSEKEEPING	(22,750)	03	14
15	NON-ALLOWABLE UTILITIES	(34,871)	05	15
16	NON-ALLOWABLE MAINTENANCE	(52,247)	06	16
17	NON-ALLOWABLE ACTIVITIES	(53,333)	11	17
18	NON-ALLOWABLE ADMINISTRATIVE EXP	(7,997)	17	18
19	NON-ALLOWABLE PROFESSIONAL SERVICES	(5,281)	19	19
20	NON-ALLOWABLE CLERICAL	(17,413)	21	20
21	NON-ALLOWABLE INSURANCE	(3,423)	26	21
22	NON-ALLOWABLE INTEREST	(62,875)	32	22
23	NON-ALLOWABLE RENT	(2,987)	34	23
24	NON-ALLOWABLE LAUNDRY	(9,393)	06	24
25	NON-ALLWABLE EMPLOYEE BENEFITS	(29,629)	22	25
26				26
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30				30
31				31
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(58,439)											(58,439)	1
2	Food Purchase	(38,705)											(38,705)	2
3	Housekeeping	(22,750)		1,870									(20,880)	3
4	Laundry													4
5	Heat and Other Utilities	(46,900)		955									(45,945)	5
6	Maintenance	(68,762)		1,511									(67,251)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(235,556)		4,336									(231,220)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			12,545									12,545	10
10a	Therapy													10a
11	Activities	(53,333)											(53,333)	11
12	Social Services			5,720									5,720	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			4,835									4,835	15
16	**TOTAL Health Care and Programs**	(53,333)		23,100									(30,233)	16
	C. General Administration													
17	Administrative	(7,997)		(472,455)									(480,452)	17
18	Directors Fees													18
19	Professional Services	(6,776)		21,868									15,092	19
20	Fees, Subscriptions & Promotions	(50,030)		1,990									(48,040)	20
21	Clerical & General Office Expenses	(58,523)		106,735									48,212	21
22	Employee Benefits & Payroll Taxes	(34,608)											(34,608)	22
23	Inservice Training & Education			18,330									18,330	23
24	Travel and Seminar	(14,814)		6,274									(8,540)	24
25	Other Admin. Staff Transportation			4,316									4,316	25
26	Insurance-Prop.Liab.Malpractice	(3,423)		1,258									(2,165)	26
27	Other (specify):*			39,917									39,917	27
28	**TOTAL General Administration**	(176,171)		(271,767)									(447,938)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(465,060)		(244,331)									(709,391)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(65,606)											(65,606)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(62,875)		304,628									241,753	32
33	Real Estate Taxes	(938)											(938)	33
34	Rent-Facility & Grounds	(2,987)		14,471									11,484	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	(132,406)		319,099									186,693	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(21,779)											(21,779)	43
44	**TOTAL Special Cost Centers**	(21,779)											(21,779)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(619,245)		74,768									(544,477)	45

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
PROVENA SENIOR SERVICES	100%	SEE ATTACHED		SEE ATTACHED		
PROVENA HEALTH	100%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PROVENA SENIOR SERVICES	100.00%	$ 1,870	$ 1,870	15
16	V	5	UTILITIES		PROVENA SENIOR SERVICES	100.00%	955	955	16
17	V	6	REPAIRS AND MAINT.		PROVENA SENIOR SERVICES	100.00%	1,511	1,511	17
18	V	10	NURSING		PROVENA SENIOR SERVICES	100.00%	12,545	12,545	18
19	V	12	SOCIAL SERVICES		PROVENA SENIOR SERVICES	100.00%	5,720	5,720	19
20	V	15	EMPLOYEE BENEFITS		PROVENA SENIOR SERVICES	100.00%	4,835	4,835	20
21	V	17	ADMINISTRATIVE	536,394	PROVENA SENIOR SERVICES	100.00%	63,939	(472,455)	21
22	V	19	PROFESSIONAL FEES		PROVENA SENIOR SERVICES	100.00%	21,868	21,868	22
23	V	20	DUES,SUBSCRIPTIONS		PROVENA SENIOR SERVICES	100.00%	1,990	1,990	23
24	V	21	CLERICAL		PROVENA SENIOR SERVICES	100.00%	106,735	106,735	24
25	V	23	INSERVICE TRAINING		PROVENA SENIOR SERVICES	100.00%	18,330	18,330	25
26	V	24	SEMINARS		PROVENA SENIOR SERVICES	100.00%	6,274	6,274	26
27	V	25	ADMIN. STAFF TRAVEL		PROVENA SENIOR SERVICES	100.00%	4,316	4,316	27
28	V	26	INSURANCE		PROVENA SENIOR SERVICES	100.00%	1,258	1,258	28
29	V	27	EMPLOYEE BENEFITS		PROVENA SENIOR SERVICES	100.00%	39,917	39,917	29
30	V	32	INTEREST-DIRECT ALLOCATION		PROVENA SENIOR SERVICES	100.00%	304,628	304,628	30
31	V	34	RENT		PROVENA SENIOR SERVICES	100.00%	14,471	14,471	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 536,394			$ 611,162	$ * 74,768	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	PHARMACY-STOCK ITEMS	$ 4,445	PROVENA SENIOR SERVICES PHARMACY	100.00%	$ 4,445	$	15
16	V	39	PHARMACY	495,416	PROVENA SENIOR SERVICES PHARMACY	100.00%	495,416		16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 499,861			$ 499,861	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	COMPUTER	$ 63,996	PROVENA HEALTH	100.00%	$ 63,996	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 63,996			$ 63,996	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PROVENA SENIOR SERVICES
Street Address: 200 E. COURT STREET, SUITE 200
City / State / Zip Code: KANKAKEE, IL. 60901
Phone Number: (815) 928-6851
Fax Number: (847) 928-6160

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	MGT FEE INCOME	5,221,293	17	$ 18,200	$	536,394	$ 1,870	1
2	5	UTILITIES	MGT FEE INCOME	5,221,293	17	9,294		536,394	955	2
3	6	REPAIRS AND MAINT.	MGT FEE INCOME	5,221,293	17	14,705		536,394	1,511	3
4	10	NURSING	MGT FEE INCOME	5,221,293	17	122,116	122,116	536,394	12,545	4
5	12	SOCIAL SERVICES	MGT FEE INCOME	5,221,293	17	55,680	55,680	536,394	5,720	5
6	15	EMPLOYEE BENEFITS	MGT FEE INCOME	5,221,293	17	47,063		536,394	4,835	6
7	17	ADMINISTRATIVE	MGT FEE INCOME	5,221,293	17	622,384	622,384	536,394	63,939	7
8	19	PROFESSIONAL FEES	MGT FEE INCOME	5,221,293	17	212,867		536,394	21,868	8
9	20	DUES,SUBSCRIPTIONS	MGT FEE INCOME	5,221,293	17	19,371		536,394	1,990	9
10	21	CLERICAL	MGT FEE INCOME	5,221,293	17	1,038,965	958,360	536,394	106,735	10
11	23	INSERVICE TRAINING	MGT FEE INCOME	5,221,293	17	178,422		536,394	18,330	11
12	24	SEMINARS	MGT FEE INCOME	5,221,293	17	61,070		536,394	6,274	12
13	25	ADMIN. STAFF TRAVEL	MGT FEE INCOME	5,221,293	17	42,016		536,394	4,316	13
14	26	INSURANCE	MGT FEE INCOME	5,221,293	17	12,250		536,394	1,258	14
15	27	EMPLOYEE BENEFITS	MGT FEE INCOME	5,221,293	17	388,552		536,394	39,917	15
16	32	INTEREST-DIRECT ALLOCAT	DIRECT ALLOCATION			2,258,265			304,628	16
17	34	RENT	MGT FEE INCOME	5,221,293	17	140,857		536,394	14,471	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,242,077	$ 1,758,540		$ 611,162	25

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PROVENA SENIOR SERVICES PHARMACY
Street Address: 1475 HARVARD DRIVE
City / State / Zip Code: KANKAKEE, IL 60901
Phone Number: (815)928-6141
Fax Number: (815)946-3238

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	PHARMACY-STOCK ITEMS	DIRECT ALLOCATION						4,445	1
2	39	PHARMACY	DIRECT ALLOCATION						495,416	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 499,861	25

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PROVENA HEALTH
Street Address: 9223 WEST ST. FRANCIS ROAD
City / State / Zip Code: FRANKFURT, IL 60423
Phone Number: (815)469-4888
Fax Number: (815)469-4864

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	COMPUTER	DIRECT ALLOCATION						63,996	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 63,996	25

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	See Supplemental Schedule											10
11	Alloc-Provena Senior Services										304,628	11
12	Non-care area portion of int										(62,875)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 241,753	14
15	TOTALS (line 9+line14)						$	$			$ 241,753	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	108,148	8
	1997	105,367	9
	1998	139,239	10
	1999		11
	2000		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PROVENA COR MARIAE CENTER COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0041046

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 110,404 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 5

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

SUPPORTIVE LIVING FACILITY - 7700 SQUARE FEET
REGIONAL CORPORATE OFFICE - 7543 SQUARE FEET

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1995	$ 670,894	1
2					2
3	TOTALS			$ 670,894	3

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1995	1964	$ 725,291	$ 24,176	35	$ 24,176	$	$ 157,147	4
5			1997	1997	1,819,208	45,484	35	45,484		193,165	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1995	130,484		20	10,107	10,107	51,363	9
10	Various			1996	326,652		20	7,748	7,748	42,613	10
11	Various			1997	119,249		20	31,613	31,613	139,442	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		-	-		-		-	68
69	Financial Statement Depreciation			61,959			(61,959)		69
70	TOTAL (lines 4 thru 69)		$ 3,120,884	$ 131,619		$ 119,128	$ (12,491)	$ 583,730	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,120,884	$ 131,619		$ 119,128	$ (12,491)	$ 583,730	1
2	ROOF REPAIRS	1998	900		20	180	180	630	2
3	CONFERENCE ROOM	1998	494		20	99	99	346	3
4	CONFERENCE ROOM	1998	72		20	14	14	50	4
5	HINGES (3) - CONFERENCE ROOM	1998	145		20	29	29	102	5
6	QUICK FENCE ROOM KIT	1998	717		20	143	143	502	6
7	PLUMBING TO INSTALL BACKFLOW	1998	13,530		20	2,706	2,706	9,471	7
8	WOOD DORRS & FRAMES (CONF RO	1998	275		20	55	55	193	8
9	RED CEDAR FENCE	1998	1,518		20	304	304	1,063	9
10	BUILDING IMPROVEMENTS	1998	157,175		20	5,239	5,239	18,337	10
11	Noncare portion of Limp	1998	(38,724)		20	(1,942)	(1,942)	(6,798)	11
12	FIRE ALARM CONTROL PANEL	1999	2,029		20	406	406	1,014	12
13	ROOFING REPAIR	1999	415		20	83	83	208	13
14	ROOFING REPAIR	1999	6,429		20	1,286	1,286	3,215	14
15	CLEAR PLATE (4) FURNISH & IN	1999	446		20	45	45	112	15
16	BUILDING IMPROVEMENTS - LOWE	1999	454		20	91	91	227	16
17	BUILDING REPAIRS - TOM W MAR	1999	493		20	99	99	247	17
18	DOORS, FRAMES & HARDWARE	1999	681		20	136	136	341	18
19	OUTSIDE LIGHTS (2) Y2K	1999	443		20	89	89	222	19
20	Noncare portion of Limp	1999	(2,523)		20	(495)	(495)	(1,237)	20
21	BOILER CONTROL REPAIRS	2000	2,182		20	436	436	654	21
22	COMPLETED SIGNED REPAIRS	2000	12,500		20	2,500	2,500	3,750	22
23	SMARTUP REPLACEMENT/VOICEMAI	2000	503		20	101	101	151	23
24	WALL FLASHING	2000	856		20	171	171	257	24
25	CRM COMMON AREA ASSESSMENT	2000	3,747		20	749	749	1,124	25
26	BALLAST AND 6 LAMPS	2000	641		20	128	128	192	26
27	RGB MAJOR BUILDING CONSULTIN	2000	11,212		20	1,121	1,121	1,682	27
28	RGB ARCHITECTURAL SERVICES	2000	855		20	171	171	257	28
29	RGB ARCHITECTURAL SERVICES	2000	1,325		20	265	265	398	29
30	CEILING TILE	2000	547		20	55	55	82	30
31	SEAL COAT COMPLETE	2000	7,008		20	1,402	1,402	2,102	31
32	REPAIR BLACKTOP (WATERMAIN B	2000	2,975		20	595	595	892	32
33	ROCKFORD BLACKTOP CONSTRUCTI	2000	3,060		20	612	612	918	33
34	TOTAL (lines 1 thru 33)		$ 3,313,265	$ 131,619		$ 136,000	$ 4,381	$ 624,431	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,313,265	$ 131,619		$ 136,000	$ 4,381	$ 624,431	1
2	Noncare portion of Limp	2000	(10,502)		20	(1,840)	(1,840)	(2,760)	2
3	1ST FLOOR REMODELING	2001	16,085		20	402	402	402	3
4	ROOFING REPAIRS	2001	1,115		20	112	112	112	4
5	2ND FLOOR REMODELING	2001	612		20	15	15	15	5
6	REMODEL NURSE'S STATION - 1S	2001	4,125		20	206	206	206	6
7	ROOFING REPAIRS - CHAPEL	2001	300		20	30	30	30	7
8	RGB ARCHITECTURAL SERVICES	2001	225		20	23	23	23	8
9	RGB ARCHITECTURAL SERVICES (	2001	225		20	23	23	23	9
10	PENTHOUSE RENOVATIONS	2001	2,264		20	226	226	226	10
11	ELEVATOR #2 PENTHOUSE ROOF R	2001	21,328		20	1,066	1,066	1,066	11
12	GAZEBO	2001	8,460		20	846	846	846	12
13	WALL REPAIRS	2001	600		20	30	30	30	13
14	LIGHTING REPAIRS	2001	708		20	35	35	35	14
15	SPRINKLER REPAIRS	2001	755		20	38	38	38	15
16	SPRINKLER REPAIRS	2001	726		20	36	36	36	16
17	LIGHTING REPAIRS	2001	594		20	30	30	30	17
18	Noncare portion of Limp	2001	(12,874)		20	(690)	(690)	(690)	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,348,010	$ 131,619		$ 136,588	$ 4,969	$ 624,099	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,348,010	$ 131,619		$ 136,588	$ 4,969	$ 624,099	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,348,010	$ 131,619		$ 136,588	$ 4,969	$ 624,099	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,348,010	$ 131,619		$ 136,588	$ 4,969	$ 624,099	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,348,010	$ 131,619		$ 136,588	$ 4,969	$ 624,099	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,348,010	$ 131,619		$ 136,588	$ 4,969	$ 624,099	1
2									2
3									3
4									4
5									5
6									6
7									7
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,348,010	$ 131,619		$ 136,588	$ 4,969	$ 624,099	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,348,010	$ 131,619		$ 136,588	$ 4,969	$ 624,099	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,348,010	$ 131,619		$ 136,588	$ 4,969	$ 624,099	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,348,010	$ 131,619		$ 136,588	$ 4,969	$ 624,099	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,348,010	$ 131,619		$ 136,588	$ 4,969	$ 624,099	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,348,010	$ 131,619		$ 136,588	$ 4,969	$ 624,099	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,348,010	$ 131,619		$ 136,588	$ 4,969	$ 624,099	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
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57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 735,097	$ 57,790	$ 62,543	$ 4,753	10	$ 305,024	71
72	Current Year Purchases	70,853	6,986	6,986	(0)	10	6,986	72
73	Fully Depreciated Assets	6,880				10	6,880	73
74								74
75	TOTALS	$ 812,830	$ 64,776	$ 69,529	$ 4,753		$ 318,890	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Plant Engineering	1989 FORD CRGO VAN	1995	$ 11,500	$	$	$	5	$ 11,500	76
77	Plant Engineering	1991 CHEVROLET FLEETSIDE	1995	14,000				5	14,000	77
78	Plant Engineering	2000 FORD ELDORADO -CAP 1	2000	42,500	4,250	4,250		5	6,375	78
79		Noncare portion of Auto	2001	(15,062)	(1,168)	(941)	227	5	(7,060)	79
80	TOTALS			$ 52,938	$ 3,082	$ 3,309	$ 227		$ 24,815	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,884,671	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 199,477	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 209,426	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,949	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 967,803	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Noncare portion of Bldg - 1964	$ 274,709	$ 17,227	$ 73,162	86
87	Noncare portion of Bldg - 1997	689,038	9,157	59,520	87
88	Noncare portion of Auto/Equip - 2001	246,330	1,168	8,756	88
89	Noncare portion of Limp - various	228,616	23,468	96,111	89
90	Noncare portion of Land - 1995	254,106	24,535	112,527	90
91	TOTALS	$ 1,692,799	$ 75,555	$ 350,076	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	ALLOC-PROVENA SENIOR SERVICES				14,471			5
6	NON-CARE AREA PORTION OF RENT				(2,987)			6
7	TOTAL				$ 11,484 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 105 Description: WELDING EQUIPMENT
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 91,760	$		$ 91,760	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			12,650			12,650	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			99,121			99,121	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				499,861		499,861	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						12,158		12,158	13
14	TOTAL			$		$ 203,531	$ 512,019		$ 715,550	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,989,309	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	11,580,827		3
4	Supply Inventory (priced at)	447,185		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	424,582		7
8	Accounts Receivable (owners or related parties)	130,474		8
9	Other(specify): See supplemental schedule	457,513		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 17,029,890	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,516,166		12
13	Land	7,818,584		13
14	Buildings, at Historical Cost	69,593,771		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	12,395,931		16
17	Accumulated Depreciation (book methods)	(33,036,528)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	72,837		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	5,331,935		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 69,692,696	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 86,722,586	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,713,455	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	494,877		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	2,662,583		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	11,659		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	636,912		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,519,486	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule	44,263,363		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 44,263,363	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 49,782,849	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 36,939,737	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 86,722,586	$	48

*(See instructions.)

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 34,695,680	1
2	Restatements (describe):		2
3	Adjustment to Reconcile Consolidated Opening Equity		3
4	and Consolidated Income to Nursing Facility Amount	1,876,601	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 36,572,281	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	367,456	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 367,456	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 36,939,737	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,949,779	1
2	Discounts and Allowances for all Levels	24,150	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,973,929	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	362,622	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 362,622	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,748	13
14	Non-Patient Meals	30	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	562,429	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 565,207	23
	D. Non-Operating Revenue		
24	Contributions	19,916	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,916	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	2,439	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,439	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,924,113	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,357,091	31
32	Health Care	1,705,866	32
33	General Administration	1,445,796	33
	B. Capital Expense		
34	Ownership	276,076	34
	C. Ancillary Expense		
35	Special Cost Centers	737,329	35
36	Provider Participation Fee	34,499	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,556,657	40
41	**Income before Income Taxes (line 30 minus line 40)****	367,456	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 367,456	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,064	2,197	$ 55,801	$ 25.40	1
2	Assistant Director of Nursing	1,276	1,394	26,839	19.25	2
3	Registered Nurses	8,248	8,519	168,198	19.74	3
4	Licensed Practical Nurses	19,432	20,856	371,548	17.81	4
5	Nurse Aides & Orderlies	49,753	52,583	613,039	11.66	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,511	3,699	42,942	11.61	8
9	Activity Director	3,486	3,688	49,457	13.41	9
10	Activity Assistants	10,982	11,466	93,341	8.14	10
11	Social Service Workers	8,341	9,161	110,166	12.03	11
12	Dietician					12
13	Food Service Supervisor	4,867	5,192	71,649	13.80	13
14	Head Cook	7,430	8,018	78,907	9.84	14
15	Cook Helpers/Assistants	22,043	23,703	175,280	7.39	15
16	Dishwashers					16
17	Maintenance Workers	8,296	9,467	109,732	11.59	17
18	Housekeepers	15,407	16,454	120,647	7.33	18
19	Laundry	5,747	6,483	54,092	8.34	19
20	Administrator	1,872	2,160	72,989	33.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,202	10,192	129,596	12.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,248	2,346	29,528	12.59	31
32	Other Health Care(specify)					32
33	Other(specify)	1,112	1,096	16,472	15.03	33
34	TOTAL (lines 1 - 33)	185,317	198,674	$ 2,390,223 *	$ 12.03	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	monthly	$ 9,519	01-03	35
36	Medical Director	monthly	12,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	monthly	1,160	10-03	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	6	338	11-03	44
45	Social Service Consultant	38	2,167	12-03	45
46	Other(specify)				46
47	PASTORAL CARE CONSULT	138	7,166	12-03	47
48					48
49	TOTAL (lines 35 - 48)	182	$ 32,950		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	12	$ 460	10-03	50
51	Licensed Practical Nurses	175	5,468	10-03	51
52	Nurse Aides	518	9,331	10-03	52
53	TOTAL (lines 50 - 52)	705	$ 15,259		53

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
THERESA WESTER-PETERS	Administrator	0.00%	$ 72,989
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 72,989

B. Administrative - Other

Description	Amount
MANAGEMENT FEES - PROVENA SENIOR SERVICES	$ 213,680
MANAGEMENT FEES - INTEREST EXPENSE	322,714
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 536,394

C. Professional Services

Vendor/Payee	Type	Amount
HINSHAW & CULBERTSON	LEGAL	$ 1,809
HEALTHCARE FURNISHINGS	FURNISHING CONSULTANT	250
PROVENA HEALTH	COMPUTER	63,996
WELLSPRING	CQI CONSULTANT	4,000
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 70,055

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,051
Unemployment Compensation Insurance	23,267
FICA Taxes	178,944
Employee Health Insurance	118,910
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
PENSION EXPENSE	21,268
DENTAL INSURANCE	16,523
OTHER EMPLOYEE BENEFITS	10,776
VISION INSURANCE	3,082
NON-CARE EMPLOYEE BENEFITS (adjusted out on page 5)	(29,626)
TOTAL (agree to Schedule V, line 22, col.8)	$ 401,195

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	61
Health Care Worker Background Check	672
(Indicate # of checks performed 96)	
DUES AND SUBSCRIPTIONS	10,366
PROMOTIONAL ADVERTISING	49,798
Alloc-Provena Senior Services	1,990
Less: Public Relations Expense	
Non-allowable advertising	(49,798)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,089

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Alloc-Provena Senior Services	6,274
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,274

**See instructions.

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. LIFE SERVICES NETWORK $4032

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 0 Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 34,499
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? YES Indicate the amount. $ 30

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? NONE
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. NOT AVAILABLE AT TIME OF FI

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees